NorCalENDO
Norcal Endocrinology & Internal Medicine

New Patient Registration

Last Name_____**Middle Name**_____

First Name_____ **Age**_____

Gender (as listed on ID card) M / F / Other **Date of Birth**_____

Preferred Pronoun_____ **Marital Status** Single/ Married / Divorced / Widowed / Separated

Social Security #_____/_____/_____ **Drivers License #**_____**State**_____

Email Address_____

Street Address_____ **Suite / Apt #**_____

City_____ **State**_____ **Zip**_____

Home Phone ( )_____ **Mobile Phone** ( )_____

Work ( )_____ **Preferred phone** H / M / W

Ok to leave a message? Y / N **Ok to leave a message with a family member?** Y / N

Name _____**Relationship**_____

PCP_____ **Phone #** ( )_____

Occupation_____ **Employer**_____

How did you hear about us? PCP / Other physician / Friend / Family member / Internet / Other

Race _____**Religion**_____**Preferred language** _____

Emergency Contact: Name _____

Phone# ( )_____ **Relationship**_____

Preferred pharmacy_____

Preferred Lab (covered by your insurance) _____

Signature_____ **Date**_____
Patient (or legal guardian if minor)

Relationship if minor_____

NorCalENDO
Norcal Endocrinology & Internal Medicine

Insurance Information

Patient's Last Name_____Middle Name_____

First Name_____ Date of Birth_____

PRIMARY INSURANCE

Name of insurance_____ ID#_____

Subscriber's Name _____ Date of Birth _____

SECONDARY INSURANCE

Name of insurance_____ ID#_____

Subscriber's Name _____ Date of Birth_____

TERTIARY INSURANCE

Name of insurance_____ ID#_____

Subscriber's Name _____ Date Of Birth_____

_____ I declare that I listed above all the health insurance coverage that I have. I have no other
Initial health insurance coverage and I understand, acknowledge and agree that failure to provide all health insurance coverage may result in me being financially responsible for all services provided by Norcal Endocrinology & Internal Medicine.

_____ I understand, acknowledge and agree to be financially responsible for all payments for services
initial provided by NorCal Endocrinology & Internal Medicine in the event that my insurance denies the claim for these services for any reason.

_____ _____
Patient's (or legal guardian if minor) Signature Date

_____
Relationship if minor

Name:	DOB :	Age:
Reason for visit:		

I have had the following medical conditions, treatments, and surgeries:	Date of diagnosis

I take the following medications:

Name of medication	Dose	How often	Date started

Allergies: (please list type of reaction i.e. rash, difficulty breathing, swelling of face etc.)

Family history: Mother (m), Father (f), sister (s), brother (b), daughter (d), Son (sn). Please check.

	m	f	s	b	d	sn	Deceased	Age
High cholesterol							Y / N	
Heart disease							Y / N	
Stroke							Y / N	
Cancer (pleases specify)							Y / N	
Type 1 Diabetes							Y / N	
Type 2 Diabetes							Y / N	
High blood pressure (hypertension)							Y / N	
Hyperthyroidism / Hypothyroidism							Y / N	

Other (please specify)													***Y / N***		
Please indicate if you have had any of the following:															
Fatigue		Easy bruising		Slow Stream		Seizures	
Malaise		Easy bleeding		Increased urinary frequency		Tremors	
Hot flushes		Back pain		Urinary retention		Anxiety	
Weight gain lbs.		Joint/bone pain		Increased thirst		Depression	
Weight loss lbs.		Water retention		Erectile dysfunction		Insomnia	
Ear pain		Chest pain		Vaginal dryness		Brittle hair	
Ear discharge		Pain in calves when walking		Sexual dysfunction		Brittle nails	
Hearing loss		Palpitations		Excessive hair growth		Rash	
Sinus pressure		Abdominal pain		Hair loss		Skin lesion	
Sore throat		Constipation		Cold intolerance		Muscle weakness	
Blurred vision		Diarrhea		Heat intolerance		Food Allergy	
Double vision		Heartburn		Difficulty swallowing		Seasonal Allergy	
Eye pain		Loss of appetite		Changes in your voice		Other	
Cough		Nausea		Dizziness		Other	
Known TB exposure		Vomiting		Numbness		Other	
Shortness of breath		Dribbling when urinating		Headaches		Other	
Wheezing		Pain when urinating		Memory loss		Other:	

Smoking history: # of packs/day # of years Quit date: / /

Alcohol use: # of drinks per day/week/ month

Vaccination: Flu Date / / Pneumonia Date / / Tetanus Date / /

For women:

Age of 1st menstrual period	Date Last menstrual period	No. of Pregnancies	Regular periods	Miscarriages	Abortions
			Y / N	Y /N #	Y /N #

Have you had gestational diabetes? Y / N

For patients with Diabetes: Type 1 / 2 Date of diagnosis: / / A1C_____ % Date: / /

Basal insulin: Lantus / Levemir / Toujeo / Tresiba / NPH	AM dose units	PM dose units

Mealtime insulin: Humalog / Novolog / Apidra / Afrezza / Regular

Dose (units):	Breakfast	Lunch	Dinner	Bedtime

For pump users:	Name of pump	Basal rate 1 From: To: u/h	Basal rate 2 From: To: u/h	Basal rate 3 From: To: u/h	Basal rate 4 From: To: u/h

Correction factor:	Sensitivity:	Active insulin time:	
Last dilated eye exam / /	Retinopathy: Y /N (PR /NPR)	Glaucoma Y / N	Cataract Y / N

I certify that the above is true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Consent, Financial Agreement and Office Policies

Treatment Authorization

The undersigned authorizes the medical providers at NorCal Endocrinology & Internal Medicine to provide medical, surgical and laboratory and radiology services deemed necessary for the treatment of illness or injury. The undersigned also authorizes the medical providers at NorCal Endocrinology & Internal Medicine to provide emergency medical treatment in the event of a medical emergency when the undersigned is unable to personally consent to treatment. The undersigned also agrees to be responsible for any charges associated with this emergency care including, but not limited to, transporting patient to the nearest hospital.

Authorization to Treat a Minor

As a legal parent/guardian of the below mentioned child/minor, the undersigned hereby authorizes the medical providers at NorCal Endocrinology & Internal Medicine to provide medical , surgical and laboratory and radiology services deemed necessary for the treatment of illness or injury. The undersigned also authorizes the medical providers at NorCal Endocrinology & Internal Medicine to provide emergency medical treatment in the event of a medical emergency when the undersigned is unable to personally consent to treatment. The undersigned also agrees to be responsible for any charges associated with this emergency care including, but not limited to, transporting patient to the nearest hospital.

Billing Information

The undersigned authorizes the release of any medical or personal information necessary to process any insurance claim and request payment directly to NorCal Endocrinology & Internal Medicine or its billing agents. The undersigned understands and agrees that he/she is personally responsible for all billed charges regardless of any insurance plan.

Assignment of Insurance Benefits

The undersigned authorizes direct payment to NorCal Endocrinology & Internal Medicine or its billing agents of any insurance benefits otherwise payable to him/her for services rendered to the patient.

Initials _____

Insurance Authorization

___ Some insurance companies require authorization for consultation and treatment. The undersigned understands that this arrangement is between him/her and his/her insurance company and that if such authorization is needed, he/she is responsible for obtaining and submitting it to the office of NorCal Endocrinology & Internal Medicine prior to each visit with the medical providers at NorCal Endocrinology & Internal Medicine. The undersigned understands that he/she needs to bring a copy of the authorization to the appointment. The undersigned understands and agrees that he/she is responsible for all charges for medical/consultative services rendered whether or not insurance authorization was obtained.

Financial Agreement

_____ The undersigned agrees that he/she is personally responsible for the total fees he/she may have incurred at the time of visit. The undersigned understands that all services are due in full within thirty (30) days of the date of service. The undersigned understands and agrees that delinquent account shall bear interest at a legal rate. In the event that the account is referred to an attorney or collection agency for collection, the undersigned will be responsible for all attorney's fees, collection expenses and costs.

Copays, deductibles and co-insurance

_____ The undersigned understands and agrees that deductibles, co-pays, and co-insurance are due and need to be paid at the time of the visit and prior to seeing the medical providers at NorCal Endocrinology & Internal Medicine before every visit. The undersigned understands and agrees to bring appropriate means of payment, insurance card(s) and photo ID to every appointment.

Update Insurance Information

_____The undersigned understands that it is his/her responsibility to notify us of any changes to his/her insurance at the time of his/ her appointment. The undersigned further agrees that he/she is responsible for all charges if current insurance information is not provided.

Initials_____

Cancellation / No Show

_____ The undersigned understands and agrees that he/she is required to cancel an appointment at least 24 hours before the visit if he/she is unable to keep the appointment, and failure to notify us within 24 hours may result in a cancellation fee of $45.

Copy of Medical Records

_____We are happy to provide copies of medical records to you or to a third party that you authorize to receive such copies. We must have a written consent from the patient or patient's legal guardian for the release of any medical records. The undersigned understands and agrees to pay the charges associated with the cost of time of staff and the cost of the supplies utilized to provide these records. Office charts and records are the legal property of NorCal Endocrinology & Internal Medicine.

Prior Authorization

_____Some insurance companies require prior authorization for certain procedures and/or medications. The undersigned understands that NorCal Endocrinology & Internal Medicine is not responsible to have insurance companies approve treatments and/or medications or lower the cost of treatments and/or medications. The prior authorization process can be very time consuming and often requiring lengthy phone calls and completion of multiple forms. We will do our best to try and get prior authorization as a courtesy and the undersigned understands and agrees that a fee may be assessed for a prior authorization request. The undersigned also understands and agrees that we may assist in completing forms such as DMV and disability forms etc. and completion of such forms may also result in additional fees that are not covered by insurance company and are the responsibility of the patient.

Notice of Privacy Practices

____ The undersigned acknowledges that he/she has read and understands the Privacy Practices of our office.

Initials_____

Prescription refills

We, at NorCal Endocrinology & Internal Medicine, refill prescriptions electronically. You may request a refill by contacting our office by phone or through our patient portal**. It is imperative that you request refills well in advance of weekends and holidays so you do not run out of medication. Please note that prescription refill requests may take as long as a week to complete.**

Agreement signature

The undersigned certifies that he/she has read and agreed to all the terms and conditions of the foregoing, received a copy of this agreement and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute and accept its terms.

Signature_____ Date_____

(Patient/Parent/Conservator/Guardian)

If signed by other than patient, indicate: Relationship_____

Patient's name_____